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The Effectiveness of Group Versus Individual Therapy in Lower Class Posthospitalized Schizophrenics

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THE EFFECTIVENESS OF GROUP VERSUS INDIVIDUAL THERAPY
IN LOWER CLASS POSTHOSPITALIZED SCHIZOPHRENICS

by

Edward M. Wittert

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University in Partial Fulfillment of
the Requirements for the Degree of
Master of Arts

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LIFE

Edward M. Wittert was born in Chicago, Illinois on October 12, 1928.

After graduating from Senn High School, Chicago, Illinois, he attended the University of Illinois and obtained a Bachelor of Science degree in Liberal Arts. He began his graduate studies in psychology at Loyola University from 1949 to 1952 and resumed his studies in 1963.

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CHAPTER I

INTRODUCTION TO THE PROBLEM

In recent years, there has been a shift away from non-specific, supervisory, routine custodial care of psychotics to new and more specific treatment approaches aimed at discharging the hospital patient. As a result, state hospital discharges have increased but so have readmission rates. The main problem is increasingly becoming one of dealing with the discharged patient so as to keep him in the community.

This basic problem is complicated by other problems which have traditionally been a part of treating mental illness. State outpatient treatment facilities have been limited in number and generally understaffed. The attitudes of the patients themselves toward aftercare in an outpatient setting are often quite negative. These patients are largely unmotivated and unwilling to involve themselves in clinic activities. Many view the outpatient facility as an extension of the hospital itself. Consequently, they associate unpleasant memories of confinement and regimentation with the posthospital treatment situation. Most of these discharged patients would prefer not to have anything to do with outpatient follow-up care, even though they have frequently been briefed and encouraged to do so prior to leaving the hospital.

Moreover, patients coming out of state hospitals are not usually regarded as good treatment prospects as measured against traditional standards. Such patients are typically not bright, fluent, insightful, responsive, highly motivated, or sophisticated. Instead, they are often

passively resistive, hostile, mute, and suspicious. Many of them have originated and interacted in culturally and materially deprived backgrounds which frustrated basic human needs. In short, these patients do not, by and large, have much appeal for the practising psychotherapist and tend to be regarded as basically untreatable.

The problem, therefore, is a difficult one. These kinds of patients are many in number, seriously ill and in need of some kind of help. It becomes increasingly important to ascertain which specific therapy approach, or combination of approaches, can best help them in posthospital aftercare situations.

The purpose of this study is to investigate the relative effectiveness of outpatient group psychotherapy versus individual psychotherapy with lower class posthospitalized schizophrenics. The author's hypothesis is that group psychotherapy is superior to individual psychotherapy for lower class posthospitalized psychotics.

CHAPTER II

REVIEW OF THE LITERATURE

Hollingshead and Redlich (1958) deal with some aspects of the problem of social class and mental illness. The authors comment that this relationship has not been extensively investigated. Their research indicates that the prevalence of treated mental illness is related to the individual's position in terms of social class and that intensive and insight-giving psychotherapeutic methods are used disproportionately more in higher social class groups. Lower class patients receive more chemical and physical therapy, as well as less experienced therapists. The authors comment on the value differences between lower class patients and therapists and conclude that strong social processes keep many psychotics institutionalized because the hospitals and community do not facilitate rehabilitation. The need, say these authors, is to find a therapy that is the right method for lower class patients.

In a three year follow-up study of posthospitalized psychotics designed to evaluate the patient's social adjustment, Bockhoven, Pandiscio and Solomon (1956) conclude that patients who received treatment in the hospital were getting along about as well as the average citizen. Evaluating the effects of aftercare with former in-patients, Hornstra and McPartland (1963) found that patients who attended outpatient clinics had significantly lower re-admission rates. The authors conclude that posthospital clinic care can facilitate reintegration.

Israel and Johnson (1956) attempted to obtain a historical perspective

of any changes that have occurred in both discharge and readmission rates. Admittedly hampered because the statistics on schizophrenic discharges are usually reported in relation to resident hospital populations, they nevertheless were able to trace the experiences of over four thousand first admission cases from 1913-1952. They found the highest discharge rate has uniformly been in patient groups under the age of 20 and that the rate declines for each subsequent age grouping. However, patients over 35 have doubled their rate of discharge during the time covered and that three out of four schizophrenics now entering Warren State Hospital in Pennsylvania are being discharged and do not require permanent readmission.

Zubin, Burdock, Sutton, and Cheek (1959) have reviewed the research on the effectiveness of specific therapies. These authors conclude that specific therapies do not make any difference, that most studies lack objective criteria, homogenous populations and findings amenable to statistical treatment, and are not subject to cross validation. Most such studies, these authors continued, fail to provide enough data about the patient and of the therapy.

In a comprehensive review of research on the outcome of therapies and psychosurgery, Staudt and Zubin (1957) take note of the conflicting reports but conclude that while the evidence points to distinct advances for treated in-patient groups as compared with untreated ones, long term follow-up studies have not shown better results for treated versus untreated patients with respect to recovery and improvement. These authors comment further about methodological defects in experimental design such as lack of homogeneity with respect to diagnostic classification, age, duration of illness, lack of controls, inadequate criteria for evaluating therapeutic outcome, etc.

Investigating the outcome of drug therapy, Williams and Walker (1961)

found that readmission rates of patients on medication were not significantly lower than patients who were not on medication. Ellsworth and Clayton (1960) also showed that drugs exerted no significant effects on readmission within one year of discharge.

Freeman and Simmons (1961) investigated kinds and patterns of professional posthospital contacts, drug therapy, and effects of specific advice to the family, with a 500 patient sample, and concluded that a patient's ability to stay out of the hospital is dependent not on therapy but rather upon the nature of the family interactions. The authors conclude that the rate of rehospitalization is independent of systematic therapeutic programs and that, in fact, patients with the best prognosis are those who have had the least attention and contact.

These same authors (1963), in a more systematic investigation of posthospitalized patients, compared the effectiveness of various specific therapies and concluded that type of treatment or even whether or not any treatment was received at all have no significant relationship to success or failure in posthospital adjustment. They question the benefits patients receive from treatment and feel such benefits probably have a more "social" function of reassuring the patient's relatives something is being done. Nevertheless, the authors do not advocate discontinuing treatment programs for they caution that such action would reduce the motivation and morale of clinic personnel.

The literature on group therapy is extensive but a hard-core body of knowledge about this specific therapy has never really emerged and the field itself lacks orderly growth and development. Research on this subject tends toward theoretical formulations and discourses on numerous techniques. Such investigations rely heavily upon clinical observation, anecdotes and descrip-

tions rather than scientific methodology and inquiry. Since the emphasis is predominantly psychoanalytical, hypotheses capable of controlled investigation are lacking, for the hypothetical constructs are often difficult to test experimentally. There is a noticeable lack in the literature of follow-up studies employing adequate criteria and separate experimental conditions, particularly in evaluating the effectiveness of group therapy over other forms of treatment.

The history of the group therapy movement seems worth touching upon. Rosenbaum and Berger (1963) comment on the notion that group psychotherapy is uniquely American and an outgrowth of pragmatic American psychiatry. However, the authors maintain this form of therapy can be traced back to the concern of ancient Greek dramatists with family relationships. Greek dramas interpreted themes of family interaction for Hellenic era audiences in an archaic form of mass psychotherapy. Shakesperian dramas dealt with similar themes in the Elizabethan era. Anton Mesmer conducted group hypnotism in the early 1700's.

Similarly, Johnson (1963) tells of small religious groups helping man to understand himself in relation to others. Trappist and Benedictine monks around the year 1000 conducted regular meetings where they were asked to criticize themselves and strive for perfection by calling attention to unrecognized traits. During the 17th century religious societies and meetings were formed in England which took similar forms of open disclosure and self-analyses.

Hadden (1955), covering more recent times, credits Dr. Joseph Pratt with forming the first therapeutic group sessions with tubercular patients in 1905 as a "time-saving" method. Recognizing its important psychological

factors, he extended the technique to other somatic illnesses shortly thereafter. L. Cody Marsh is credited with one of the earliest applications of group techniques with psychoneurotics between 1909-1914. Introducing group psychotherapy for the first time in a mental hospital a short while later, Dr. Marsh's slogan was "by the crowd have they been broken; by the crowd they shall be healed." E. W. Lazell, working under W. A. White at St. Elizabeths Hospital after World War I, experimented with group lectures to hospitalized schizophrenics. Psychoanalytically oriented group therapy with hospitalized psychotics began around 1930 using free association and interpretation. Around that time, too, A. A. Low arranged for post-discharge meetings and began "Recovery, Inc." In the 1930's group therapy was used more extensively for the treatment of psychosomatic illness as well as with hospitalized mental patients. S. R. Slavson used group therapy with children and began to study the technique's processes and dynamics. J. W. Klapman and S. H. Foulkes published texts in the 1940's. During World War II, group therapy was a useful expedient for the military services. The American Group Psychotherapy Association was founded in 1942 and the International Journal of Group Psychotherapy began publication in 1951. At the present time, several of the professional disciplines utilize group therapy techniques.

In discussing some general aspects of group therapy, Frank (1955) comments that all group techniques try to produce changes in patient attitudes. The group goal is to realize as fully as possible the goals of the separate members. All therapeutic groups have a leader who selects members, whose guidance is sought, and toward whom the members feel a degree of dependency. Most groups encourage emotional expression, analysis of feelings, and respect for one another's views and actions. Most practitioners agree

that the group has to be homogenous enough to give individual members emotional support but not too cohesive as to inhibit useful emotional tensions.

The specific literature on group therapy with psychotics is mainly theoretical in nature and usually based on the particular writer's observations over a period of time. In one of the earliest insightful discourses on the technique with functional psychotics, Marsh (1931) criticizes the advisability and benefits of using only individual psychotherapy with psychotics because of the shortage of psychiatrists, lack of a standard rationale for individual therapy, the vagueness and unproven status of psychoanalysis, the psychotic's inaccessibility to individual therapy, the fact that improvement percentages are low and the lack of adequate time, space and personnel. This author was convinced, even at this early date, that the task of treating psychotics had to be accomplished through group methods. He was convinced that group therapy could treat more patients, mentally and emotionally re-educate them, provide opportunities for emotional release, help motivate them toward improvement and provide an opportunity for them to work out social difficulties. Marsh claims that "the method fills the great need of providing a presentation of reality which is more attractive and more potently motivating than the ideas and situations that motivate mental disease." He concludes with the observation that there is no substitute for individual therapy and that this latter approach is required to some extent in every case.

Evseeff (1948) wrote about setting up programs in a state hospital, and believed that group psychotherapy not only benefits the patients but helps the therapists in their understanding of the patients. More patients are reached through group therapy and are therefore persuaded that they are

not forgotten. Group therapy usually meets with favorable responses from in-patients who view the program as a welcome break from daily hospital routine.

Frank (1963) observes that the use of group psychotherapy has expanded. Group leaders and kinds of groups vary tremendously in their theoretical and technical characteristics. He believes that the growth of these group techniques not only reflect an attempt to utilize limited personnel as much as possible but also points up the cultural phenomenon of multiple small groups within present-day society. The author goes on to say that group activity facilitates communication between patients and staff, influences the patient favorably and leads to beneficial changes in hospital structure and functions. Groups offer a wider range of therapeutic experiences which may therefore coincide with a greater number of individual needs, and give the patient more of a feeling of freedom and responsibility while fostering a sense of belongingness.

Spotnitz (1957) notes that attitudes toward group psychotherapy for borderline schizophrenics are becoming more favorable. He criticizes social isolation as a treatment method for severely disturbed people. He feels that, in the group, the psychotic's resistances can and should be supported and reinforced, that groups should be composed of individuals with similar backgrounds with different personalities, capable of emotional expression, with talking the main activity.

Wolman (1960), operating from a psychoanalytic perspective, believes individuals interact according to their needs and perceptions of their surroundings. Their main need is survival and they perceive in terms of their own and their environment's ability and willingness to satisfy their needs. Group psychotherapy has the advantage of many transferences. Selection is

important from this point of view and "should" be limited to those patients who can stand the group and vice-versa. The latent schizophrenic experiences new relationships and, through group interaction, develops more favorable balances between giving and receiving. Group activity facilitates the interpretation of hostility which is so prevalent in these types of patients. The author concludes that group psychotherapy strengthens the ego of the latent schizophrenic.

Sohmerhorn (1955) comments how, in the initial period of defensiveness and resistance, the patient gradually shifts his attention from the content of his conversation to his role in the group. Then, the group focuses on this role while accepting the patient and, in a final stage, the group helps the patient plan a program geared to better adjusting in other social situations, develop life goals, etc.

Standish and Semrad (1963) also list stages of group psychotherapy with psychotics. The first is a testing out situation characterized by hostility. The second is free expression of psychotic material. The third stage revolves around introspection, mutual criticism and working through of emotional problems, and the fourth involves planning for the future. Groups help the patient relate himself to others, encourage the expression of hostility and the release of other feelings, and provide an atmosphere of interchange to learn how to deal with others effectively.

Slavson (1964) is one of the important names in the group therapy movement, and the man who is generally credited with introducing the term "group psychotherapy." He operates from a psychoanalytic framework of dogmatic rules and assertions. He questions whether psychoanalytically oriented therapy groups are suitable for ambulatory psychotics but he adds that small

numbers of such patients have improved in groups of non-psychotics. Slavson emphasizes the importance of the setting, i.e., selection and grouping of patients, the personal and professional characteristics of the therapist and the physical surroundings. He does not deal with the problems or feasibility of treating groups of schizophrenics and he states rather decisively that no more than one or two borderline patients can be included in an analytic group.

Johnson (1963) writes that group treatment techniques differ for psychotics. The therapist should be more supportive because anxiety mounts quickly in these patients. The group creates an arena for increased socialization, fosters new identifications with peers and with the group therapist, diminishes feelings of isolation, encourages participation and release of feelings and creates a mutually cooperative spirit of problem-solving. Dilution of transference feelings in groups reduces anxiety and facilitates greater interaction.

The problem of effectiveness of group therapy is as yet unresolved. Whitaker and Lieberman (1964) comment that the issue is not now so much one of describing variables operating in group therapy as it is deciding whether looking at these variables is useful in arriving at the main goal, that is, helping the patient grow and adjust. Proponents of the psychoanalytical viewpoint argue that attention to group dynamics and characteristics is detrimental to therapy and that dynamics as such are to be analyzed and made inoperative. The opposite view maintains that group processes are a necessary and important part of the therapeutic process.

Powdermaker and Frank (1953) examine the effectiveness of group psychotherapy in a comprehensive, complex study of heroic proportions involving

numerous criteria of effectiveness, situation analyses and detailed observations and descriptions. Their approach is subjective and qualitative more than quantitative or statistical; indeed, the authors feel that preoccupation with controls and experimental design is premature in the field of psychotherapy. Their study does not compare group with individual therapy but does compare a ward of patients who received group therapy with a control group. It was found that the experimental group received more discharges and were granted more privileges but the differences were not statistically significant. The controls needed more shock therapy because of greater depression and withdrawal while the experimental group tended more "to do something" about their upsets. Observations revealed that group therapy stimulated the patients more in regard to participation in external activities and in verbal relations with others. Left unanswered, of course, is the question as to whether any other therapy would have produced similar results.

Pinney (1956) writes about a group of six outpatient schizophrenics discharged from the Brooklyn State Hospital, ages 20-35, with a high school education, and chosen for their degree of motivation and insight. He describes their feelings as dependent, ambivalent and passively aggressive. Positive transferences were encouraged and delusions and hallucinations were treated as real feelings. The patients tended to think of the group as something other than therapy and more like a regular social group.

Standish and Simrad (1963) admit that effectiveness of group therapy is difficult to evaluate. They cite 165 treated patients, 80% female, of widely differing diagnostic categories and age groupings. The results were better with acute than with chronically disturbed patients, using percentage released as the criterion of effectiveness. Statistical significance is not

reported, however.

Frank (1952) reports on 174 chronic schizophrenic in-patients divided into a group therapy experimental group and a control group receiving routine hospital ward care. Significantly more discharges resulted on the experimental ward where these patients showed more openly aggressive behavior and increased social awareness. Again, however, one cannot conclude that the type of therapy was the significant factor here, for any other therapy might have produced the same significant difference in results.

Peters and Jones (1951) tested two groups of hospitalized schizophrenics before and after therapy with a Porteus Maze test and a mirror tracing test. One group received group psychotherapy, the other routine hospital care. The authors report a statistically significant difference in test performance favoring the experimental group. Assuming first that these instruments have a certain amount of validity as measures of social adjustment, the authors conclude that group psychotherapy facilitates improvement in social adjustment. Again, they do not answer the question of whether another kind of therapy would be just as effective.

Appleby (1963) reports on 53 hospitalized chronic schizophrenics divided into three experimental groups (treatment with a psychiatric aide, a total push program involving various therapies and a specific hospital therapy program formulated by a psychiatric team) and one control group receiving no intensive therapy program. Using selected behavioral rating scales, the author reports significant differences between all experimental groups and the control group, but no significant difference between the experimental groups themselves. The author recommends better controls should be instituted in further research.

Greenblatt and Brown (1955) provide the reader with a summary of these kinds of research problems. They begin by lamenting the fact that treatment centers for the mentally ill have not captured the interest of the public at large as much as has the institutional care of general illnesses. The authors maintain, like so many others, that the function of a mental hospital is not only in administration, but also in fostering a treatment program aimed at earliest possible discharge. At their own installation, the Boston Psychopathic Hospital, a "total push" program involving varied therapies is emphasized in promoting discharges, but with no controls. According to these authors, a good part of the difficulty in doing research on specific therapies lies in establishing controls. Staff members excluded from participation, or else labeled "controls," become frustrated and develop decreased motivation. The participating personnel need feedback of results of their efforts. The time lag between initial measures and the analysis and interpretation of data can create anxiety, suspiciousness and poor motivation, all of which can subtly alter the entire social situation. The authors do conclude on an optimistic note that even chronic institutionalized patients can be re-motivated and resocialized with maximum utilization of all physical and social resources.

Zubin (1953) does a thorough job in further pointing out the difficulties and problems in evaluating treatment results and he also advocates a series of conditions and designs. He starts out with the notion that a group of patients undergoing a specific treatment cannot alone serve as a criterion for effectiveness of that therapy. There must be a comparable group of untreated cases contrasted with the treated group. He goes on to further cite the difficulties in ascertaining the nature and cause of mental disease,

noting that there is often disagreement among even highly qualified professionals and that there is no uniformity of opinion as to the definition and measurement of terms like "recovery," "cure," "improved," and the like. Evaluation of these factors is very subjective and depends upon clinical appraisals rather than on objective factors. Moreover, the author continues, individuals closely involved in the outcome are often closely involved in the crucial evaluations, too. He criticizes rating scales as "atomistic" and cites the pitfalls of data collecting of discharged patients. In evaluating specific therapeutic effectiveness, he notes patients are usually not randomly selected to begin with and differ from hospital to hospital and from practitioner to practitioner. There is also a spontaneous recovery rate which is expected regardless of the specific therapy under investigation, too. Variables such as age, sex, time of onset and duration of the disease should be taken into account. The author comments on the confused, contradictory results obtained. He goes on to outline an ideal and ambitious program of matching patient groups at various therapy centers throughout the country and applying different therapies on a five year follow-up basis.

CHAPTER III

PROCEDURE

This present study was designed to overcome some of the alleged defects in previous investigations of this nature, particularly with respect to patient selection and controls. In recent months, the author has been an active participant in a research project sponsored by the Psychology Department at the Mental Health Center, Chicago, Illinois. This clinic is a state-supported, out-patient mental hygiene unit operating under the jurisdiction of the Department of Mental Health. The overall research project is aimed at studying the posthospital adjustments of patients released from mental hospitals.

The author's study concerns itself with 102 hospital-diagnosed conditionally discharged schizophrenics from ten State of Illinois mental hospitals, of low social class, all single, ranging in age from 17 to 40, usually living with their families.

These patients were divided into three groups of 34 each. The first group received individual psychotherapy only, which is defined as psychotherapy on a one-to-one patient-therapist basis. The second group received group psychotherapy only. Patients in these two groups were selected on the basis of the above criteria from December, 1962 to November, 1963. Therapy assignments were randomly made by an orienting committee of two psychologists and a physician primarily on the basis of therapist availability. The goals for both groups were to get the patient into the clinic as soon as possible after release from the hospital. An active "push" of patients in both groups was

equally instituted to get them to come to the clinic. The first step involved contacting each patient by phone. The responsible relatives were also talked to. Then a rather firm form letter was sent to each patient, with a carbon copy sent to the relatives, inviting the patients to come in. If the patient failed to respond, other letters were quickly sent out until the patient responded by coming in.

The third group was a control group composed of 34 randomly selected patients meeting the above selection criteria from all patients conditionally discharged in 1961 who were referred to the Mental Health Center for follow-up. These patients received routine clinic care in the sense that no specific psychotherapy assignment was made and contacts were aimed primarily at keeping a diagnostic check of the patients' state of remission and medication status. Since most of the patients in the experimental groups were on medication, it was decided to choose as control patients only those who had been on medication following their conditional discharge.

The therapists were twelve psychologists at the masters or doctoral level on the staff at the Mental Health Center most of whom had more than two years of supervised experience in psychotherapy. More than half of the therapists conducted both individual and group sessions. Since the hypothesis of the investigation was formulated later by the author, it can be assumed that the therapists did not have a predisposition one way or another. Moreover, the therapists were not particularly instrumental in rehospitalizing patients since the family and/or the physician actually make the decision to rehospitalize; the therapists simply facilitated the rehospitalization process by referring the patient to the physician for examination, usually at the request of the family. In general, the therapists were not considered to be

an important variable for this study. The author was investigating types and effectiveness of therapies, not therapists. Consequently, the therapists are "collapsed" in this study.

As the criterion of "low social class," the author chose the McGuire and White (1955) occupational index of social status. All 102 patients selected fit into the lower half of the index, both in terms of "level" and "kind" of occupation.

The criterion of "effectiveness of therapy" was community tenure, i.e., length of time that patients were able to stay out of the hospital. Alternate measures of "effectiveness" were considered, such as social adjustment, economic adjustment, degree of improvement, whether self-sustaining or a burden to the family, participation in community activities, etc. None of these measures were considered to be as significant as community tenure. In the author's opinion, such measures are not easily defined and depend too heavily upon inventory and behavioral rating scales, interviews with emotionally involved people, projective, achievement, or performance tests, adjustment inventories, etc., all of which are open to questions of validity. Since few deny that the first and foremost goal of posthospital aftercare is keeping the patient out of the hospital and in the community, it seemed most appropriate to make community tenure the criterion of "effectiveness."

In addition to the above criteria according to which all the patients were originally selected, i.e., hospital diagnosis, marital status, a selected age range and level and kind of occupation, the author also gathered data for all patients on additional variables to include race, sex, educational level, number of previous hospitalizations, total length of hospitalizations, medication status, state of remission shortly after discharge, age at first admis-

sion to a mental hospital and number of clinic contacts prior to return to hospital. This was done in order to take into consideration some variables that other investigators have regarded as possible prognostic determinants.

The data in this study was obtained from an orienting clinical "team," therapist reports, hospital records and clinic charts. Each group was compared as to the effectiveness of therapy according to the criterion described above.

CHAPTER IV

RESULTS

The groups were compared according to selected variables. Age was analyzed first. In the group that received individual therapy, 17 were 29 years of age or under and 17 were 30 to 40 years of age. In the group that received group therapy, 21 were 29 years of age or under and 13 were 30 to 40 years of age. In the control group, 17 were 29 years of age or under and 17 were 30 to 40 years of age. Chi square tests were run on the group versus individual therapy groups alone and on all three groups combined. In both calculations, the age differences between the groups were not statistically significant ($P > .05$).

Race was considered next. Of the patients who received individual therapy, 24 were white and 10 were Negro. Of the patients receiving group therapy, 18 were white and 16 were Negro. The control group was composed of 23 white and 11 Negro patients. Chi square tests were run on the group versus individual therapy groups alone and on all three groups combined. In both calculations, the differences between the groups were not statistically significant ($P > .05$).

The individual therapy group was made up of 20 males and 14 females. Both the group therapy and control group had 18 males and 16 females each. Chi square tests were run on the group versus individual therapy groups alone and on all three groups combined. In both instances, the differences between the groups were not statistically significant ($P > .05$).

Educational levels were examined. Of the patients who received individ-

ual therapy, 21 did not complete high school and 13 had at least a completed high school education. Of the patients who received group therapy, 22 did not complete high school and 12 had at least a completed high school education. Of the control group, 18 did not complete high school and 16 had at least a completed high school education. Chi square tests were run on the group versus individual therapy groups alone and on all three groups combined. Both calculations revealed no statistically significant differences between groups ($P > .05$).

Evaluating total number of previous hospitalizations, it was found that 27 patients in both the group and individual therapy groups had two or less, and 7 had more than two. In the control group 20 had two or less, and 14 had more than two. Chi square tests were run on the group versus individual therapy groups alone and on all three groups combined. In both cases, there were no statistically significant differences ($P > .05$).

Medication status was the next variable studied. Twenty-six patients who received individual therapy were also on medication, eight were not. Twenty-one patients who received group therapy were also on medication, nine were not, and the status of four others could not be determined. All of the control patients were on medication. Chi square tests were run on the group versus individual therapy groups and on all three groups combined. In both instances, there were no statistically significant differences ($P > .05$).

Total length of hospitalizations was assessed. In the individual therapy group nine patients had a total hospitalization of less than 12 months, 10 patients had been hospitalized for 12-24 months, and 15 patients had previously been in the hospital more than 24 months. Of patients who received group therapy, 16 had a total hospitalization of less than 12 months, 8

patients had been hospitalized for 12-24 months, and 10 patients had previously been in the hospital more than 24 months. In the control group, 16 patients had previous hospitalizations totaling less than 12 months, 6 patients were in for 12-24 months, and 12 patients had stayed in a hospital more than 24 months. Chi square tests were run on the group versus individual therapy groups alone and on all three groups combined. The differences between the groups were not statistically significant ($P > .05$).

Since no control group estimates of state of remission made by the Orientation Committee were available, only the group and individual therapy groups were examined on this variable. Of the patients who eventually received individual therapy, nine were estimated by the Orientation Committee to be in good remission, ten were estimated to be in moderate remission, and thirteen were estimated to be in poor remission. On two patients, estimates were not made. Of the patients who received group therapy, five were estimated to be in good remission at time of discharge, sixteen were judged to be in moderate remission, and nine were classified as being in poor remission. For four patients, no estimates were made. A chi square test on the two groups revealed no statistically significant differences ($P > .05$).

Age at first admission to a mental hospital was next considered. A total of 26 patients in the individual therapy group had first entered a mental hospital by age 25 or earlier. Eight patients in this group first entered a mental hospital after the age of 25. Of the group therapy patients, 19 first entered a mental hospital by age 25 or earlier, and 15 after age 25. Of the control patients, 22 first entered a mental hospital by age 25 or earlier, and 11 after age 25. The age of first hospitalization was unavailable for

one patient in this last group. Chi square tests were run on the group versus individual therapy groups alone and on all three groups combined. In both cases, there were no statistically significant differences between the groups ($P > .05$).

Contacts with the clinic and its therapeutic services were seen as a possible alternative explanation for the success of the group members. However, an analysis of covariance on contacts by time out of the hospital indicates that there was no significant difference in the number of contacts experienced by the group as opposed to individual patients.

It was demonstrated, therefore, on the basis of sample selection and statistical controls, that there were no significant differences between the three groups on the basis of diagnosis, race, age, sex, marital status, education, occupational levels and kinds, number of previous hospitalizations, total length of hospitalizations, medication status, state of remission, and age at first admission to a mental hospital.

The next step was to investigate whether there were any significant differences between the groups in terms of total time the patients were able to remain out of the hospital. Table 1 summarizes the results. Twenty-seven patients in group therapy were able to stay out of the hospital 12 months, 18 patients in the individual therapy group remained out 12 months, and 20 patients in the control group were able to remain out one year.

The Mann Whitney U Test, corrected for ties, compared the individual groups with each other. The difference between patients who received group therapy versus patients who received individual therapy was found to be statistically significant in favor of group therapy patients ($z = 2.51$. $P < .006$ for a one-tailed test of significance).

Table 1

Performance table, showing community tenure
for each group on month by month basis

# mos. out	Individual Therapy Patients	Group Therapy Patients	Control Group Patients
1	0	0	0
2	3	0	2
3	2	1	1
4	4	1	2
5	2	1	2
6	3	0	2
7	0	2	1
8	0	1	2
9	1	1	2
10	1	0	0
11	0	0	0
12	18	27	20
Total	34	34	34

The difference between patients who received group therapy and the control group was also statistically significant in favor of the group therapy patients ($z = 1.70$. $P < .05$ for a one-tailed test of significance).

The difference between the control group and patients who received individual therapy was not statistically significant.

The results clearly establish the superiority of group therapy over both individual therapy and routine outpatient clinic care for lower class posthospitalized schizophrenics from the viewpoint of keeping these patients in the community and out of the hospital. The results also indicate that patients who received individual psychotherapy do not have a significantly better record of community tenure than those who received only routine clinic care.

CHAPTER V

DISCUSSION

The problem at the outset was not only to investigate the particular effectiveness of a specific therapy but also to do so in a particular setting with a selected group of patients. Various other authors have pointed out the benefits of group therapy with psychotics, but few have integrated their ideas with the provocative findings of investigators like Hollingshead and Redlich (1958). Therefore, the author would like to discuss these significant findings from this particular frame of reference. This frame of reference highlights the socio-cultural problem areas in dealing with mental illness, an area the author feels has been neglected in previous investigations of the specificity and effectiveness of therapeutic techniques.

Hollingshead and Redlich (1958) emphasize the important social differences between most therapists and lower class patients. Such differences in social class, habit patterns, mores, goals, and social values can create stumbling blocks in the communication necessary to do therapy with lower class patients. The uninformed, poorly educated and unsophisticated mental patient often immediately sets out to structure the therapy in terms of his experiences and convert the therapist into a powerful, potentially punitive authority figure. The therapist, moreover, is usually unwilling to play this role and perhaps even resents this kind of rigid structuring. In dealing with these kinds of patients, the therapist is frequently confronted with a fearful, suspicious person who does not accept psychotherapy as a source of help. More often than not, this patient sees his mental illness as a shameful contamination which bears a social stigma and the likelihood of an hereditary taint.

In short, the low social class patient often fights a losing battle with his own guilt over his illness, he misses seeing the value or potential of therapy, and he does not understand what the therapist is attempting to do.

At the same time, therapists may not always be aware of some of their own reactions toward these patients. Some of them will have difficulty understanding and accepting culturally-influenced patterns of behavior which deviate from their own notions about social interactions. They may react with concealed rejection toward the patient's inability to think and act according to their own standards and values. They may silently communicate their unfriendly reception and perhaps unknowingly begin to screen out such patients by classifying them as untreatable. Many of them seek the "good" patient, someone who shares their own value systems and with whom they feel comfortable, someone who will not arouse their own anxieties and hostilities by engaging in thoughts and activities foreign to their own background and experiences.

It is the author's contention that these social differences between the upper or middle class therapist and low social class patient introduce negative prognostic influences into the therapy situation. Such influences are the product of interpersonal distancing, lack of close emotional rapport, uncooperative patient attitudes and impaired communication in general. It is the author's belief that such adverse influences on a one-to-one patient therapist basis can at least partially account for the fact that the posthospital performance of patients in this study who received only individual therapy was no better than the control patients. This result, incidentally, is similar to the trend (not statistically significant) reported by Freeman and Simmons (1963) that patients who were able to stay out of the hospital for one year were less likely to have received individual out-patient treatment

than those who were unable to remain in the community.

It is the author's opinion that the problem of treating lower class patients cannot be properly investigated without the recognition and admission of the importance of the relevant social and cultural factors which exert their influences in the treatment situation. It is incumbent upon therapists to first recognize their personal reactions to the existing social class differences, and then learn to better understand these kinds of patients. Moreover, it is important for them to recognize their own limitations as therapists and scale down treatment goals in the face of occasionally serious reality problems facing the lower class patient.

The search for suitable treatment methods for these patients has barely begun. Future research on this problem might be oriented toward therapies which are perhaps more concrete and less complicated than some present techniques, always with the intention of taking into account both the relevant psychological and psychosocial factors.

In this context, the author hopes to have made a small contribution. His hypothesis that group therapy is more suitable for lower class posthospitalized schizophrenics was confirmed by the results of this study. The reasons for the significant differences in favor of group therapy with lower class schizophrenics are undoubtedly complex and overlapping but can be partly understood and summarized on the basis of the foregoing discussion. The group provides its members with emotional support that may be lacking in individual therapy. The group promotes the release of emotions and associated tensions usually without penalty of rejection. The group facilitates and sustains communication processes and exposes the individual member to new ideas and insights. Such a setting increases feelings of belongingness and security,

and can be more stimulating than a one-to-one patient-therapist relationship as it widens perceptual horizons and social experiences. Moreover, a group situation keeps reality constantly before the patient, provides him with criteria to test out, and helps him plan for the future. The characteristic intuitive "feel" that one schizophrenic sometimes has for another which allows for more acceptable and insightful handling of psychotic material can be maximized through group interaction. In a group situation, too, it might be expected that a group of the patient's peers would be more likely to apprehend specific individual problems and, through group discussion, clarify them for the therapist. In this way, the group sessions can almost be viewed as a training ground for the therapist on learning to understand lower class value systems and then deploying this understanding toward more effective therapy.

The author believes that group therapy offers a potentially fruitful area for exploration in search of a specific, effective therapy for lower class hospitalized and posthospitalized patients. In general, group interaction diminishes the effects of patient-therapist biases, reduces the patient's defensiveness, anxieties and suspiciousness, and promotes processes of psychological growth and self-development. While the one-to-one patient-therapist relationship can be a sterile, artificial series of contacts foreign to both parties, the group situation, on the other hand, is less formally structured and minimizes the risk of perceptual distortions predicated upon social class differences. At the same time, group therapy is better able to cope with the practical problems of limited numbers of trained therapists and over-crowded treatment facilities.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The purpose of this study was to investigate the relative effectiveness of out-patient group psychotherapy versus individual psychotherapy with lower class posthospitalized schizophrenics. The major hypothesis was that group psychotherapy is superior to individual psychotherapy for lower class post-hospitalized psychotics. Three groups of 34 patients each were investigated. All patients were diagnosed schizophrenics of low social class, single, ages 17 to 40, on conditional discharge from ten Illinois State mental hospitals. One group received individual psychotherapy, the second group received group therapy. The third group was a control group of patients who received only routine, irregular out-patient clinic contacts, usually centering around supervision of medication or state of remission. Variables such as race, age, sex, diagnosis, marital status, education, occupation, number of previous hospitalizations, total length of hospitalization, medication status, state of remission at discharge, age of first admission to a mental hospital, and number of posthospital clinic contacts were matched and no significant differences regarding these variables was found between the groups. The data was statistically analyzed using community tenure as the criterion of therapeutic effectiveness, i.e., the length of time patients were able to stay out of the hospital.

It was demonstrated that patients who received group therapy were able to remain out of the hospital significantly longer than patients who received individual or routine clinic contacts. It was also found that patients who were treated individually did not have a significantly better record of

community tenure than the control group. The tentative conclusion is that group therapy is more effective with lower class posthospitalized schizophrenics than either individual psychotherapy or routine attendance at an outpatient facility. These results were discussed on the basis of the social class differences existing between these kinds of patients and therapists.

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APPROVAL SHEET

The thesis submitted by Edward M. Wittert has been read and approved by two members of the Department of Psychology.

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated, and that the thesis is now given final approval with reference to content, form, and mechanical accuracy.

The thesis is therefore accepted in partial fulfillment of the requirements for the Degree of Master of Arts.

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Jan. 1965
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